Anthem BlueCross BlueShield

Dental Benefit Policy

Anthem Dental
Family [Value] [Enhanced]

**[IMPORTANT: This policy covers
ONLY Diagnostic & Preventive and Basic Restorative services
for covered persons age 19 and over.]**

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine this policy. If you are not satisfied, for any reason, with the terms of this policy, you may return it to us within those 10 days. Return to [Anthem Blue Cross and Blue Shield], PO Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

NOTICE TO BUYER:
This certificate provides dental benefits only.

INTRODUCTION

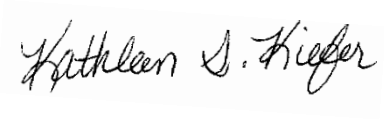
This policy is a legal contract between you, the policyholder ("policyholder", "you", and "your") and Anthem Blue Cross and Blue Shield ("Anthem", "we", "us", and "our"). This policy is governed by the laws of the State of Maine. By paying the first *premium* and accepting this policy, you agree to be bound by the terms of this policy.

We may arrange for others to provide certain administrative services on our behalf, including eligibility determination and *premium* billing. To ensure efficient administration of your benefits, you must cooperate with them in the performance of their duties.

We agree to provide coverage for benefits as set out in this Dental Benefit Policy.

READ YOUR POLICY CAREFULLY. The entire policy sets forth, in detail, the rights and obligations of both you and Anthem. It is therefore important that you read your entire policy carefully.

Thank you for choosing Anthem Blue Cross and Blue Shield!



Kathleen S. Kiefer
Corporate Secretary

Administered by:
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[Administrative Offices
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(877) 604-2158]

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SUMMARY OF DENTAL BENEFITS

The Summary of Dental Benefits is a summary of the *deductibles*, *waiting periods*, *coverage percentages* and *benefit maximums* that apply when you receive *covered services* from a *dentist*. Please refer to the Covered Services section of this *policy* for a more complete explanation of the specific services covered. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions of this *policy*, including any attachments or riders.

Coverage Year
A *coverage year* is a 12 month period in which *deductibles* and *benefit maximums* apply. Your *coverage year* is January 1st through December 31st.

Deductible
The *deductible* is the amount you must pay before we begin to pay for *covered services*. You have to meet your *deductible* every *coverage year* before we will pay for *covered services*.

Deductible amount for *covered persons* through the end of the month in which they turn 19 $[25][50] per *covered person*
[*Deductible* amount for *covered persons* age 19 and older ..... $50 per *covered person*]

Waiting Periods
A *waiting period* is the length of time you must be covered under this *policy* before we pay benefits. Certain types of services may have *waiting periods* under your *policy*. You are eligible for benefits once you meet your *waiting periods*.

Type of Service	**Waiting Period**
For covered persons age 19 and older	
Basic Restorative	6 months
[Endodontic Services	12 months
Periodontal Services	12 months
Oral Surgery Services	12 months
Major Restorative Services	12 months
Prosthodontic Services	12 months]
[For covered persons through the end of the month in which they turn 19	
Cosmetic Orthodontic Care	12 months]

Benefit Maximum
The following *benefit maximums* are the dollar amount we will pay for *covered services* for each *covered person*, subject to the *coverage percentages* identified above. If you do not reach your annual *benefit maximums*, unused amounts will not carry over to the next *coverage year*.

	Participating Dentist	**Non-Participating Dentist**
Annual *Benefit Maximum* (*for covered persons through the end of the month in which they turn 19*)	no limit	
Dentally Necessary Orthodontic Care Lifetime Benefit Maximum	no limit	
[Cosmetic Orthodontic Care Lifetime Benefit Maximum	$1,000 *(combined for participating and non-participating dentists)]*	
[Annual *Benefit Maximum* (*for covered persons age 19 and older*)	$[750][1,000] *(combined for participating and non-participating dentists)]*	

Annual Out of Pocket Maximum
For *covered persons* through the end of the month in which they turn 19, there is an annual out of pocket maximum. This amount is the most you will pay out of pocket in a *coverage year* for *essential health benefits* before we will pay 100% of the *maximum allowed amount* for *essential health benefits*. Your *premium* amount, charges for services that are not covered, or charges for services received from a *non-participating dentist* do not apply to the out of pocket maximum.

Annual Out of Pocket Maximum for 1 child $350
Annual Out of Pocket Maximum for 2 or more children $700

Coverage Percentages
After you have met any applicable *deductibles*, we pay the following percentages of the *maximum allowed amount* for *covered services*. The *maximum allowed amount* is different for *participating and non-participating dentists*. If you see a *non-participating dentist*, you may have more out-of-pocket expenses. To learn more about how the *maximum allowed amount* is determined, see the section called Dental Providers and Claims Payments.

Essential Health Benefits
The following benefits are available to *covered persons* through the end of the month in which they turn 19 only. You have to meet your *deductibl*e before we will pay for *covered services*. However, the *deductible* is waived for fluoride treatments.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	[70][80]%
Basic Restorative Services	[60][80]%	[50][60]%
Endodontic Services	[50][80]%	50%
Periodontal Services	[50][80]%	50%
Oral Surgery Services	[50][80]%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%
[Cosmetic Orthodontic Care	50%	50%]

Covered persons age 8 through age 18 may be eligible for Cosmetic Orthodontic Care if the recommended treatment is not eligible for Dentally Necessary Orthodontic Care. Cosmetic Orthodontic Care is not an Essential Health Benefit.

Adult Dental Benefits
The following benefits are available to *covered persons* age 19 and older only. You have to meet your *deductibl*e before we will pay for *covered services*.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	50%
Basic Restorative Services	[50][80]%	[25][40]%
[Endodontic Services	[30][50]%	[15][25]%
Periodontal Services	[30][50]%	[15][25]%
Oral Surgery Services	[30][50]%	[15][25]%
Major Restorative Services	[30][50]%	[15][25]%
Prosthodontic Services	[30][50]%	[15][25]%
Orthodontic Services	Not covered	Not covered]

DEFINITIONS

This section defines terms that have special meanings within this booklet. Terms that are defined in this section will be italicized throughout the booklet. When you see an italicized word, you should refer to this section.

Benefit maximum – the maximum amount we will pay for covered services for each covered person during the coverage year. See the Summary of Dental Benefits for your benefit maximums.

Coinsurance - a percentage of the maximum allowed amount for which you are responsible. Your coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Coverage percentages - a percentage of the maximum allowed amount that we will pay for covered services.

C**overed person** - any person that is covered under this policy.

Covered services – services or treatments that are performed, prescribed, directed or authorized by a dentist. Covered services are listed in the Covered Services section. To be considered covered services, services must be:

- within the scope of the license of the dentist performing the service;
- given while you are covered under this policy;
- a service that is not excluded or limited under this policy; and
- listed as a benefit within this booklet.

Coverage year – a 12 month period in which deductibles and benefit maximums apply. Your coverage year is January 1st through December 31st.

Deductible – the dollar amount you are responsible to pay each coverage year before we will pay for covered services. Your deductible amount is listed in the Summary of Dental Benefits.

Dentally necessary orthodontic care – a dental service where at least one of the following criteria are present: (A) There is spacing between adjacent teeth which interferes with the biting function; or (B) There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the covered person bites; or (C) Positioning of the jaws or teeth impair chewing or biting function; or (D) On an objective professionally recognized dental orthodontic severity index the condition scores at a level consistent with the need for orthodontic care; or (E) Based on a comparable assessment of items (A) through (D), there is an overall orthodontic problem that interferes with the biting function.

Dentist – a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry. This includes a licensed Dental Hygienist.

Dependent – a person in your family that is eligible for coverage under this policy. See the Eligibility and Termination section for more information.

Effective date – the date your coverage begins under this policy.

Essential Health Benefits (EHB) – for the purposes of this coverage, Essential Health Benefits are those pediatric oral services that we are required to cover under the Patient Protection and Affordable Care Act and any other application regulations. EHB and its provisions apply to covered persons through the end of the month in which they turn 19 only.

Identification card / ID card – a card we issue to you that shows your name, your ID number, and important phone numbers to contact us.

Maximum allowed amount – the maximum amount we will pay for covered services. See the section Dental Providers and Claims Payments for more information on how we determine the maximum allowed amounts.

Non-participating dentist – a dentist who has NOT signed a written agreement with us to service the program identified in this booklet.

Participating dentist – a dentist who has signed a written agreement with us to service the program identified in this booklet. Participating dentists have agreed to our maximum allowed amount as payment in full for covered services.

Policy – is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, and any endorsements.

Policyholder – is the person who has applied and been accepted by us for coverage under this policy.

Premium – the periodic charges you must pay for coverage under this policy.

Waiting period - a waiting period is the length of time you must be covered under this policy before we pay benefits. See the Summary of Dental Benefits for your waiting periods.

DENTAL PROVIDERS AND CLAIMS PAYMENTS

You do not have to select a particular *dentist* to receive dental benefits. You have the freedom to choose the *dentist* you want for your dental care. However, your *dentist* choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your *dentist* is a *non-participating dentist*. There may be differences in the payment amount compared with a *participating dentist* if your *dentist* is a *non-participating dentist*.

We make payments only when the covered dental procedures have been completed. We may require additional information from you or your *dentist* before a claim can be considered complete and ready for processing. In order to properly process a claim, we may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for dental services rendered by *participating* and *non-participating dentists* is based on the *maximum allowed amount* for the type of service performed. There may be different levels of reimbursement for the *maximum allowed amount* depending upon whether you elect to receive services from a *participating* or a *non-participating dentist*.

The *maximum allowed amount* is the maximum amount of reimbursement we will pay for covered dental services provided by a *dentist* to a *covered person*. For *participating dentists*, the *maximum allowed amount* will be reimbursed according to the schedule of maximum allowable charges. For *non-participating dentists*, the *maximum allowed amount* will be reimbursed according to the table of allowances.

You will be required to pay a portion of the *maximum allowed amount* if you have not met your *deductible* or have a *coinsurance* due. In addition, when you receive *covered services* from a *non-participating dentist*, you may be responsible for paying any difference between the *maximum allowed amount* and the *dentist's* actual charges. This amount may be significant.

When you receive dental care from a *dentist*, we will apply processing rules to the claim submitted for that dental care. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect our determination of the *maximum allowed amount*. For example, your *dentist* may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, our payment will be based on the single *maximum allowed amount* for the single procedure code rather than a separate *maximum allowed amount* for each billed procedure code.

Likewise, when multiple procedures are performed on the same day by the same *dentist* or another *dentist*, we may reduce the *maximum allowed amount* for those additional procedures, because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent a duplicate payment for a dental procedure that may be considered incidental or inclusive.

Participating Dentists

A *participating dentist* is a *dentist* who has signed a written provider service agreement agreeing to service the program identified in this *policy*. For *covered services* performed by a *participating dentist*, the *maximum allowed amount* is based upon the lesser of the *dentist's* actual charges or the schedule of maximum allowable charges. Because *participating dentists* have agreed to accept the *maximum allowed amount* as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon *maximum allowed amount*. However, you may receive a bill or be asked to pay a portion of the *maximum allowed amount* if you have exhausted your coverage for the service, have not met your *deductible*, have a *coinsurance* due, have received *non-covered services*, or have exceeded the dental *benefit maximum* as outlined in the Summary of Dental Benefits. Please call member service at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision.

Please refer to your *ID card* for the name of the dental program that participating providers have agreed to service when you are choosing a participating provider.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this *policy* are considered *non-participating dentists*. For *covered services* you receive from a *non-participating dentist*, the *maximum allowed amount* will be the lesser of the *dentist's* actual charges or an amount based on our *non-participating dentist* fee schedule, referred to as the table of allowances, which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with us, and other industry cost, reimbursement and utilization data. The table of allowances may be different from the *maximum allowed amount* reimbursed to *participating dentists*.

Unlike *participating dentists*, *non-participating dentists* may send you a bill and collect for the amount of the *dentist's* charge that exceeds the *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating dentist* charges. This amount may be significant. Choosing a *participating dentist* will likely result in lower out of pocket costs to you. Please call member service at (877) 604-2142 for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision.

Member service is also available to assist you in determining the *maximum allowed amount* for a particular service from a *non-participating dentist*. In order for us to assist you, you will need to obtain the specific procedure code(s) from your *dentist* for the services the *dentist* will render. You will also need to know the *dentist's* charges to calculate your out of pocket responsibility. Although member service can assist you with this pre-service information, the *maximum allowed amount* for your claim will be based on the actual claim submitted.

Your Cost Share

For certain *covered services* and depending on your dental program, you may be required to pay a part of the *maximum allowed amount* (for example, *deductible* and/or *coinsurance*). Your *deductible*, *coinsurance* and out-of-pocket costs may vary depending on whether you received services from a participating or *non-participating dentist*. Specifically, you may pay higher out-of-pocket costs when using *non-participating dentists*. Please see the Summary of Dental Benefits in this *policy* for your cost share responsibilities and limitations, or call member service to learn how this *policy's* benefits or cost share amounts may vary by the type of *dentist* you use.

Payment of Benefits

You authorize us to make payments directly to *participating dentists* for *covered services*. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for *covered services*.

Once a *dentist* gives a *covered service*, we will not honor a request for us to withhold payment of the claims submitted.

YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A *NON-PARTICIPATING DENTIST*. WHEN SERVICES ARE OBTAINED FROM A *NON-PARTICIPATING DENTIST*, ANY BENEFITS PAYABLE UNDER THIS *POLICY* ARE PAID DIRECTLY TO YOU, UNLESS YOU HAVE ASSIGNED YOUR BENEFIT TO THE *DENTIST* WHO PROVIDED THE SERVICE.

COVERED SERVICES

All *covered services* are subject to the terms, limitations, and exclusions of your *policy*. See the Summary of Dental Benefits for your cost share amounts, such as *deductibles* and/or any *coinsurance*.

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this *policy*. We evaluate the procedures submitted to us on your claim to determine if they are a *covered service* under this *policy*.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was *dentally necessary orthodontic care*. See the section Orthodontic Care for more information. [If it is determined the care is not *dentally necessary orthodontic care*, it may be covered at the cosmetic orthodontic care rate. See your Summary of Dental Benefits to determine if you have cosmetic orthodontic care coverage.]

Your *dentist* may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this *policy*. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your *policy*. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your *dentist*. You are responsible for any costs that exceed the allowance, in addition to any *coinsurance* or *deductible* you may have.

The decision as to what dental care treatment is best for you is solely between you and your *dentist*.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your *dentist*. It provides you and the *dentist* with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the *dentist* and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, endodontic, periodontic, oral surgery, prosthodontic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the *policy* benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the *policy* may affect our final payment.

You can ask your *dentist* to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your *dentist* can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental *ID card*.

Pediatric Dental
Essential Health Benefits

We cover the following dental care services for *covered persons* through the end of the month in which they turn 19 when they are performed by a licensed *dentist*, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic and Preventive Services

Oral Exams. Covered 2 times per 12 months.

Radiographs (X-rays)

- Bitewings - Covered 2 sets per 12 months.
- Full Mouth (Complete Series) - Covered 1 time per 60 months.
- Panoramic – Covered 1 time per 60 months.
- Periapicals.
- Occlusal films.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if the *covered person* is 13 or younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 months.

Sealants or Preventive Resin Restorations. Any combination of these procedures is covered 1 time per tooth every 36 months.

Space Maintainers and Recement Space Maintainers

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Consultations. Covered when given by a provider other than your treating *dentist*.

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kind of fillings covered under this plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, we will pay up to the *maximum allowed amount* for an amalgam filling. You will be responsible to pay for the difference, if the *dentist* charges more, plus any applicable *deductible* or *coinsurance*.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Periodontal Scaling & Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.

Partial Pulpotomy for Apexogenesis - Covered on permanent teeth only.

Pin Retention

Prefabricated or Stainless Steel Crown. Covered 1 time per 60 months for *covered persons* through the age of 14.

Therapeutic Drug Injection

Endodontic Services

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments.

- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

Full Mouth Debridement. This is a non-surgical periodontal service to treat diseases of the gums (gingiva) and bone that supports the teeth. Covered 1 time per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 months. Covered for permanent teeth only.

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft

The following complex surgical periodontal care services are not subject to the benefit frequency stated above:

- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Soft tissue allograft

Crown Lengthening

Oral Surgery Services

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions. Surgical removal of 3rd molars is covered only when symptoms of oral pathology exist.

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Removal of exostosis-per site

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collect – apply autologous product - Covered 1 time per 36 months.
- Excision of pericoronal gingiva
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

Post Surgical Services

- Treatment of complications, unusual circumstances

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a *dentist's* office by the *dentist* or an employee of the *dentist* that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations, Covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same *maximum allowed amount* for an amalgam filling. You're responsible to pay for any amount over the *maximum allowed amount*, plus any applicable *deductible* and *coinsurance*.

Inlays. Covered at the same frequency as an amalgam filling. Inlays will be paid up to the same *maximum allowed amount* for an amalgam filling. You're responsible to pay for any amount over the *maximum allowed amount*, plus any applicable *deductible* and *coinsurance*.

Onlays and/or Permanent Crowns. Covered 1 time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the *maximum allowed amount* for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable *deductible* and *coinsurance*.

Recement an Inlay, Onlay or Crown.

Inlay, Only or Crown Repair. Covered 1 time per 36 months. The narrative from your treating *dentist* must support the procedure.

Restorative Cast Post and Core Build-Up. Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60 months if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth per 60 months.

Occlusal Guards. Covered 1 time per 12 months for *covered persons* age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase. ***Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.***

Repairs and Replacement of Broken Clasp(s)

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance and the narrative from the treating *dentist* supports the service.

Denture Adjustments

Partial and Bridge Adjustments

Dentures and Partial (removable prosthodontic services. Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services. Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to service as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 60 months.

The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable *deductible* and *coinsurance*.

Recementation of Bridge (fixed prosthetic).

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. It's recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. You or your orthodontist should send it to us so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontic Care
This plan will only cover orthodontic care that is dentally necessary – at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite
- The position of your jaw or teeth impairs your ability to bite or chew
- On an objective, professional orthodontic severity index, your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes.
Orthodontic care may include the following types of treatment:

- Pre-Orthodontic Treatment Exams. Periodic visits with your *dentist* to establish when orthodontic treatment should begin.
- Periodic Orthodontic Treatment Visits
- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care
Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this *policy*.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this *policy* ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this *policy*, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this *policy*. We will not pay for any portion of your treatment that was given before your *effective date* under this *policy*.

What Orthodontic Care Does NOT Include. The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this *policy*.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Adult Dental **We cover the following dental care services for *covered persons* age 19 and older** when they are performed by a licensed *dentist*, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.]

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 24 months.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60 months.
- **Periapical(s)** - 4 single x-rays are covered per 12 months.
- **Occlusal** - Covered at 2 series per 24 months.

Dental Cleaning (**Prophylaxis)** - Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

  Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and the optional treatment, plus any *deductible* and/or *coinsurance* that applies.

  LIMITATION: Coverage for amalgam or composite restorations will be limited to 1 service per tooth surface per 24 months.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Brush Biopsy - Covered 1 time per 36 months, per *covered person* age 20 to 39. Covered 1 time per 12 months per *covered person* age 40 and above.

Endodontic Services

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Root Canal Retreatment**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planing - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this *policy*.

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36 months per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60 months.

Surgical Reduction of Fibrous Tuberosity - Covered 1 time per 6 months.

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical services.

Major Restorative Services

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

LIMITATION: The patient must pay the difference in cost between the *maximum allowed amount* for the *covered services* and optional treatment, plus any *deductible* and/or *coinsurance* that applies. Covered 1 time per 24 months.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any *deductible* and/or *coinsurance* that applies.

Onlays and/or Permanent Crowns - Covered 1 time per 7 years if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION**:** Porcelain/ceramic substrate onlays/crowns – Benefits will be limited to the *maximum allowed amount* for a porcelain to noble metal crown. The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any applicable *deductible* and/or *coinsurance*.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12 months per tooth when the submitted narrative from the treating *dentist* supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prosthodontic Services

Tissue Conditioning - Covered 1 time per 24 months.

Reline and Rebase - Covered 1 time per 24 months:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 time per 6 months:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating *dentist* supports the procedure.

Denture Adjustments - Covered 2 times per 12 months:

- When the denture is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24 months:

- When the partial or bridge is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the partial or bridge.

Removable Prosthodontic Services (Dentures and Partials) - Covered 1 time per 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If 7 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- If 7 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the *covered service*.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 7 years for *covered persons* age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS

Coverage is NOT provided for:

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a *covered person* receives the benefits in whole or in part. This exclusion also applies whether or not the *covered person* claims the benefits or compensation. It also applies whether or not the *covered person* recovers from any third party.
- Dental services or health care services not specifically covered under the plan (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the *covered person* became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except when given with covered complex surgical services and given by a *dentist* or by an employee of the *dentist* when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Dental services performed other than by a licensed *dentist*, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the *policy*.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another *covered service*.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Pulp vitality tests.

- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.
- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances are not a covered benefit.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a *covered person* under this *policy*. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.
- For *covered persons* age 19 and older, corrections of congenital conditions during the first 24 months of continuous coverage under this *policy*.
- Dental implant maintenance or repair to an implant or implant abutment.
- [Endodontic, Periodontal, Oral Surgery, Major Restorative, Prosthodontic Services and] Orthodontic services for *covered persons* age 19 and older.

ELIGIBILITY AND TERMINATION

This section will tell you who is eligible for coverage under this *policy* and how to add or remove *dependents* from your *policy*. It will also give you information about how your coverage ends under this *policy*.

Who is Eligible

Policyholder
To be a *policyholder*, the applicant must meet the following requirements:

a) Be determined by the Exchange to be a Qualified Individual for enrollment in a Qualified Health Plan (QHP).
b) Be a United States citizen or national; or
c) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
d) Be a Maine resident;
e) Submit proof to Anthem to confirm *dependent* eligibility;
f) Agree to pay for the cost of *premium* that Anthem requires;
g) Reveal any coordination of benefits arrangements or other dental benefit arrangements for the applicant or *dependents* as they become effective;
h) Not be incarcerated (except pending disposition of charges);
i) Not be covered by any other group or individual dental plan.

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State Supplementary Payments (SSP); and
- Reside in the service area of the Exchange.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be eligible for Medicaid based on the receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Not be receiving optional State Supplementary Payments (SSP); and reside in the service area of the Exchange.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address); or
2. Has entered without a job commitment

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with *covered persons* in multiple Exchange service areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the *dependent* meets a residency standard.

Dependents

To be enrolled as a *dependent*, you must be listed on the enrollment form completed by the *policyholder*, be determined by the Exchange to be a Qualified Individual, and meet all *dependent* eligibility criteria. The following *dependents* of a *policyholder* may be enrolled under this *policy*:

1. Spouse, meaning:
   a. Married
   b. Qualified domestic partner, if all of the following criteria are met:
      i. are not related by blood closer than permitted under applicable state marriage laws;
      ii. are not married and do not have any other domestic partners;
      iii. are at least 18 years of age and have the capacity to enter in a contract;
      iv. share a residence;

   All references to spouses in this *policy* will include domestic partners.

2. *Dependent* children up to the age of 26, including:
   a. You and your spouse's natural-born and legally adopted children.
   b. Children for whom you or your spouse are the legal guardian.
   c. Stepchildren.
   d. Grandchildren for whom you are the legal guardian
3. Disabled children who have reached age 26 if:
   a. they are primarily dependent upon you or your spouse;
   b. they are incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
   c. were disabled before they reached age 26.

The Exchange may require the *policyholder* to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Newborn and Adopted Child Coverage

Newborn children of the *policyholder* or the *policyholder's* spouse will be covered for an initial period of 60 days from the date of birth. Coverage for newborns will continue beyond the 60 days, provided the *policyholder* submits through the Exchange a form to add the child under the *policyholder's* contract. The form must be submitted along with the additional *premium*, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enrollee your child under this *policy*, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this *policy*, and once approved by the Exchange, we will provide the benefits of this *policy* in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any *dependent* age limit. Any claims payable under this *policy* will be paid, at our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrolment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or *dependent* loses his or her Minimum Essential Coverage. The term Minimum Essential Coverage means any of the following: Government sponsored programs; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a state; coverage under a grandfathered health plan, and such other health benefits coverage, such as a state health benefits risk pool, or as the Secretary of HHS recognizes);

- A Qualified Individual gains a *dependent* or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and

A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide

Policy Effective Date

Your policy will begin on the *effective date,* which is the first day of the *coverage year* following your selection made during the Exchange's annual open enrollment period. Your actual *effective date* will be determined by the date you submit a completed application and pay any applicable *premiums* to the Exchange.

Effective dates for special enrollment period:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit are not effective until the first day of the following month in which you provided notice, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses his or her Minimum Essential Coverage, coverage is effective on the first day of the month following the event, as long as the application is received within 30 days of the event.

Termination

When Your Coverage Ends
Your coverage and that of your *dependents* will end on the earliest of the following dates:

1. The date determined by the Exchange as a result of you requesting termination with appropriate notice to the Exchange or the QHP;
2. The end of the month in which you are no longer eligible;
3. [The end of the month in which your *dependent* is no longer a *dependent* as defined in this *policy*;]
4. The last day of the month for which a *premium* has not been paid, subject to the grace period; or
5. The date the *policy* ends as determined by the Exchange. You will be notified by the QHP as required by law.

When a Child's Coverage Ends
Covered children will receive benefits for the *essential health benefit* coverage in this *policy* until the end of the month in which they turn age 19. At the end of the month in which they turn 19, unless we are given notice to cancel, they will be covered under the Adult Dental Benefits in this *policy* to the end of the month in which they reach age 26, unless they are disabled. Please see the Who is Eligible section for more information.

Cancelling Your Policy

You may cancel this *policy* at any time by written notice delivered or mailed us; effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, we will return promptly the unearned portion of any *premium* paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. [If you elect coverage and subsequently cancel your *policy*, you and your *dependents* will not be allowed to re-enroll in the *policy* until Open Enrollment from November 1 through January 31 of the benefit year.

Notification Prior to Termination

You have the right to designate an individual of your choice, or to change this designation, to receive a notification that your coverage under the *policy* will terminate 10 days prior to the date the *policy* terminates. If you request a third party designation form, it will be mailed to you within 10 days of your request. In the event that your coverage under the *policy* is terminating due to non-payment of *premium* due to a cognitive impairment or functional incapacity, your coverage may be reinstated. You or a person authorized to act on your behalf, must request reinstatement within 90 days after termination. Upon reinstatement, you will have 15 days to pay any unpaid *premium* from the date of the last *premium* payment at the rate that would have been in effect had the *policy* not been terminated. If you do not pay the unpaid *premium* in within this time, your coverage may not be reinstated and we are not responsible for claims incurred after the initial date of cancellation.

Renewability

This *policy* will continue as long as your *premiums* are paid, subject to the grace period and you continue to be a Qualified Individual as determined by the Exchange.

We reserve the right to terminate the *policy*, in whole or in part, at any policy renewal date by giving you written notice at least 31 days prior to the renewal date. Termination of the *policy* will result in loss of coverage for all *covered persons*. If the *policy* is terminated, the rights of the *covered persons* are limited to *covered services* incurred before termination. Termination is without prejudice to any claim originating while the *policy* was in force.

We will not increase the *premiums* or decrease the benefits provided in this *policy* before any renewal date, and not without 30 days prior written notice.

Reinstatement

If your *policy* is terminated because you do not pay your *premium* within the grace period you may have it reinstated. Your *policy* will be reinstated if we, or an agent authorized by us, accept your *premium* payment after we have terminated your *policy*. If we accept your *premium*, we will not require an application to reinstate your *policy*.

However, we may ask for a new application to accept your premium and reinstate your *policy*. If we ask for a new application we will only re-instate your *policy* after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 days after we received your application, it will be deemed approved.

If your *policy* is reinstated, only dental care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated *premium* to the period for which the *premium* was not paid. However, we will not apply *premium* to any period over 60 days prior to reinstatement.

HOW TO FILE CLAIMS

A claim must be filed in order for us to pay for *covered services*. Most *dentists* will file your claim for you. If your *dentist* does not file the claim, you must file your claim with us. This section will tell you how to file a claim.

Notice of Claim

We must receive written notice of claim within 20 days from the date you received dental care. If it was not reasonably possible to send the notice within that time, send it to us as soon as is reasonably possible. Notice given to us, or an agent authorized by us, with information sufficient to identify you will meet the notice of claim requirements. If the notice does not include sufficient data we need to process the claim, the necessary data must be submitted to us within the time frames specified below or no benefits will be payable except as required by law.

Claim Forms

Many *dentists* will file the claim form for you. If the forms are not available, either send a written request for claim forms to us or contact member service and ask for a claim form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claim forms, you can send us other documents as your proof of claim. Your proof of claim must have the following:

- Name of patient
- Patient's relationship to you
- Identification number
- Date, type and place of service
- Your signature and the *dentist's* signature

We accept the standard American Dental Association (ADA) claim form used by most *dentists*.

Proof of Claim

We must receive your written proofs of claim within 20 days after the date you received dental care. If proof of claim is not sent within that time, your claim will not be reduced or denied, as long as it was not possible to send your proof. However, you must send it as soon as reasonably possible. In any case, the proof of claim must be sent to us no later than 15 months after the date of service, unless you were legally incapacitated.

Time of Payment of Claim

Any payments for *covered services* will be made as soon as possible upon receipt of proper written proof of claim, but no later than 30 days.

If more information is needed to process your claim, an extension of up to 30 days may be requested. The request for more information will be sent to you before the end of the initial twenty (20) days and will itemize the information or documents we need. You will have 15 working days after you receive the request to provide us with the information. We will make a claim decision within 30 days after we receive the requested information. Without complete information, your claim will be denied.

In the event the claim is denied, we will send notice within 30 days after we receive written proof of claim. The notice will tell you the reason(s) the claim was denied.

If we do not respond within the time frames stated above, we are responsible to pay the applicable interest on the payments due.

Address for Claims

Please send completed claim forms and any proofs of claim to the following address:

Anthem Blue Cross and Blue Shield
[PO Box 1115
Minneapolis, MN 55440-1115
(877) 604-2158]

HOW TO FILE AN APPEAL

This section explains and offers instructions on what to do if you disagree with a denial or modification of benefits for a dental claim, or are dissatisfied with the dental treatment or a service rendered by either a *dentist* or by us, and wishes to file a grievance or appeal.

Grievances
If you are dissatisfied, you may file a grievance with us verbally or in writing. If you have a grievance about any aspect of our service, such as the processing of a dental claim, a benefit determination, or *premium* billing, or the dental treatment or services rendered by a *dentist*, they may contact member service at the toll free number listed below or on your *ID card*.

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

We will acknowledge receipt of the grievance and provide a resolution within the state's specified grievance resolution time frames. If you are not satisfied with the resolution of the grievance, an appeal may be filed as explained in the appeals section below:

Appeals
You may file an appeal verbally or in writing. We will acknowledge receipt of the appeal and provide a resolution within the state's specified appeal resolution time frames. An appeal may be filed for any dental claim that has been denied in whole or in part or to request a reconsideration for any adverse grievance decision. In the appeal, please state plainly the reason(s) why the treatment or service should not have been denied or why the adverse grievance decision should be reversed. All appeals will be reviewed by an individual not previously involved in the original decision. Reviews involving clinical judgment will be reviewed by a qualified clinical reviewer. Please include any documents or information that may have a bearing on our decision in our review but were not previously available to us.

Please send written appeals to the following address or contact us at the toll-free phone number listed below:

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

You may designate a representative (e.g., the health care provider or anyone else of your choosing) to file a grievance or appeal or your behalf. We must receive a written designation before working with the representative.

The grievance and appeals process is governed by laws and regulations, and may be modified from time to time by us as those laws may require.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to ass you in filing a grievance or appeal.

GENERAL POLICY PROVISIONS

Premium Calculations and Payment

The payment of any *premium* will keep the coverage in force until the next *premium* due date, subject to the grace period provision of the *policy*.

Your *premium* amount, the *premium* payment schedule and the payment method is stated on the [Policy Confirmation][Declaration Page] that you received following your enrollment.

We may change the *premium* for this *policy* by giving you a written notice of at least 60 days prior to any change.

For *premium* and payment questions, call [(877) 604-2158].

Grace Period

You have a grace period of 31 days to pay your *premium*. This *policy* will remain in effect during the grace period.

Entire Contract; Changes

This *policy*, including any endorsements or attached papers, is the entire contract of insurance. Its terms can be changed only a written endorsement signed by one of our authorized officers. No agent or employee of ours is authorized to change the terms or waive any other the provisions of this *policy*.

Time Limit on Certain Defenses

After you have been insured under this *policy* for 3 consecutive years, we will not use any material misstatements you may have made in your application for this *policy*, except any fraudulent misstatements, to either void this *policy* or to deny a claim for any *covered services* incurred after the expiration of such 3 year period.

Legal Actions

No action at law or in equity will be brought to recover on this *policy* sooner than 60 days after written proof of claim has been furnished in accordance with the requirements of this *policy*. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Misstatement of Age

If a *covered person's* age or sex has been misstated, we will adjust the *premiums* and/or benefits under this contract. The benefits will be the amount the *premiums* paid would have purchased at the correct age and/or sex.

Conformity to Law

The laws of the State of Maine will be used to interpret any of this *policy*.

Clerical Error

Clerical error by us will not invalidate insurance otherwise validly in force nor continue insurance otherwise terminated.

Dental Examination

We have the right to have a *dentist* examine you, at our own expense, as often as is reasonably required while processing a claim under this *policy*. We also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Change in Beneficiary

You can change your beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the *policy*, unless the designation of the beneficiary is irrevocable.

Coordination of Benefits

We do not coordinate benefits.

International Emergency Dental Program

This *policy* includes coverage for emergency dental care while traveling. Please see the Emergency Dental Care for the World Traveler flyer included with this *policy*.

CONTACT US

MEMBER SERVICE DEPARTMENT
[(877) 604-2158]

Hours: 8:00 a.m. to 4:30 p.m. Central Time
Monday - Friday

For claims and eligibility:

Anthem Blue Cross and Blue Shield
[PO Box 1115
Minneapolis, MN 55440-11115]

Send your appeal to:

Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
[PO Box 1122
Minneapolis, MN 55440-1122]

Our website:

www.anthem.com

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your *ID card* for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the member service telephone number on the back of your *ID card*.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD:711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។
(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong *ID card* para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services?
Call the Member Services number on your *ID card* for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.